DOCUMENT RESUME

ED 250 894 EC 171 132

TITLE Developmental Disabilities, State of Minnesota: A Three Year Plan, 10/1/83-9/30/86.
INSTITUTION Minnesota Governor's Planning Council on Developmental Disabilities, St. Paul.; Minnesota State Planning Agency, St. Paul.
PUB DATE Jun 83
NOTE 48p.
PUB TYPE Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Developmental Disabilities; Elementary Secondary Education; Financial Services; Program Administration; *Program Development; *State Standards; *Statewide Planning
IDENTIFIERS *Minnesota

ABSTRACT

The document presents Minnesota's state plan for developmentally disabled residents. A question and answer format is used along with a narrative and references to state and federal law, regulations, and court rulings on the following topics (sample subtopics in parentheses): definition and impact of developmental disabilities (effects on individuals, families, and communities); the Governor's Planning Council on Developmental Disabilities (council members, roles); the administering agency for the Developmental Disabilities Program; the state context (issues and concerns influencing services, scope of services, priority service areas, council's major concerns during the 3 year plan period); goals, objectives, and funding (projected budget for FY 1984, application procedures for subgrantees); and assurances. Appended is a summary of testimony from a public forum. (CL)

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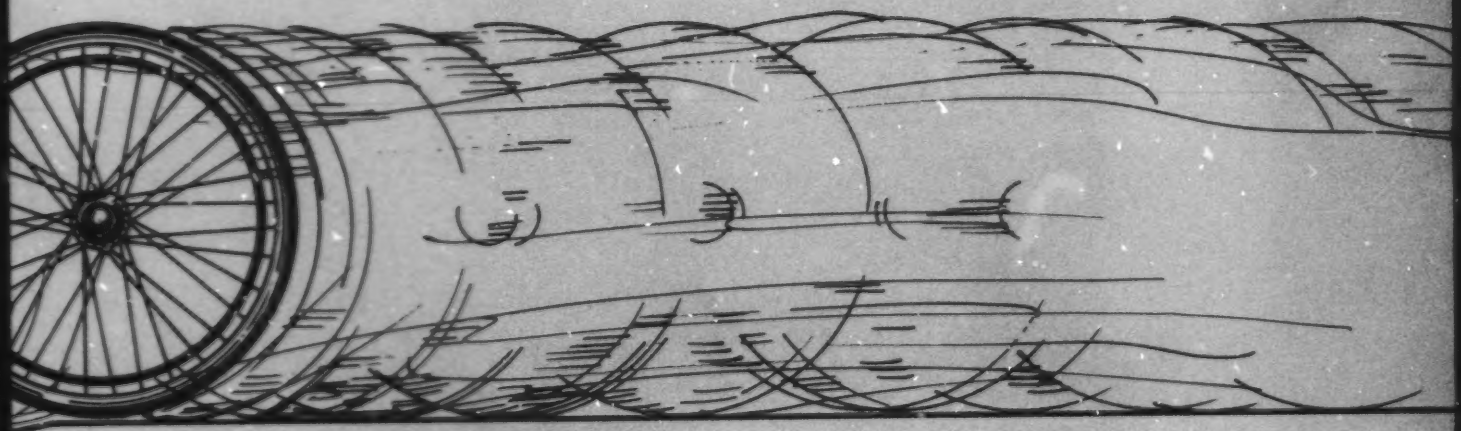
STATE OF MINNESOTA

DEVELOPMENTAL DISABILITIES

A THREE YEAR PLAN
10/1/83–9/30/86



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June 28, 1983

Mr. Robert Vogt, Regional Program Director
Administration on Developmental Disabilities
Office of Human Development Services
U.S. Department of Health and Human Services
Chicago, Illinois 60606

Dear Mr. Vogt:

As Governor of Minnesota, I am pleased to submit the Developmental Disabilities Three-Year State Plan for the three-year period between October 1, 1983 and September 30, 1986. The State Plan was developed with the participation and cooperation of the public and the Minnesota Governor's Planning Council on Developmental Disabilities.

The Minnesota Governor's Planning Council on Developmental Disabilities endorses the goals and objectives contained in the plan. The Council will work actively through the designated state administering agency, the Minnesota State Planning Agency, to implement these goals and objectives.

Sincerely

Rudy Perpich

RUDY PERPICH
Governor

DEVELOPMENTAL DISABILITIES
THREE-YEAR STATE PLAN

October 1, 1983-September 30, 1986

STATE OF MINNESOTA

Submitted by
The Minnesota Governor's Planning Council
on Developmental Disabilities

This State Plan is a joint endeavor of the Governor's Planning Council on Developmental Disabilities and the Developmental Disabilities Program, Minnesota State Planning Agency.

Richard P. Nelson

Chairperson
Minnesota Governor's Planning Council
on Developmental Disabilities

Thomas J. Triplett

Director
Minnesota State Planning Agency

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SECTION 1:

Developmental Disabilities: Definition and Impact

1.1
What Are Developmental Disabilities?

Developmental disabilities are severe, chronic mental and/or physical impairments which occur at an early age, are likely to continue indefinitely, and have a pervasive effect on an individual's functional abilities and need for services.

In Public Law 95-602, the Developmental Disabilities Assistance and Bill of Rights Act, Congress stated its findings as follows:

- there are more than two million persons with developmental disabilities in the United States;
- individuals with disabilities occurring during their developmental period are more vulnerable and less able to reach an independent level of existence than other handicapped individuals who generally have had a normal developmental period on which to draw during the rehabilitation process;
- persons with developmental disabilities often require specialized lifelong services to be provided by many agencies in a coordinated manner in order to meet the persons' needs;
- general service agencies and agencies providing specialized services to disabled persons tend to overlook or exclude persons with developmental disabilities in their planning and delivery of services; and
- it is in the national interest to strengthen specific programs, especially programs that reduce or eliminate the need for institutional care, to meet the needs of persons with developmental disabilities. (Section 101 (a))

1.1.1
The Federal Definition of "Developmental Disability"

Public Law 95-602 as amended, the Developmental Disabilities Assistance and Bill of Rights Act, defines a developmental disability as:

a severe, chronic disability of a person which —

- is attributable to a mental or physical impairment or combination of mental and physical impairments;
- is manifested before the person attains age twenty-two;
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity:
  self care
  receptive and expressive language
  learning
  mobility
  self-direction
  capacity for independent living, and
  economic self-sufficiency; and
- reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated. (Section 102(7))

1.1.2
Minnesota's Application of the Federal Definition

The Governor's Planning Council on Developmental Disabilities uses the federal definition in its Request for Proposal, and requires grant recipients to meet that definition in implementing grants.

1.2
How Many People Have Developmental Disabilities?

The population of developmentally disabled persons in Minnesota is estimated at 98,638. This estimate is based on a prevalence rate of developmental disabilities of 2.42 percent of the state's 1983 population. However, less than 1.00 percent of Minnesota's total population would be receiving services in the state's system.

1.3
How Do Developmental Disabilities Affect Individuals, Their Families, and Their Communities?

Developmental disabilities such as mental retardation, cerebral palsy, epilepsy or autism, put obstacles in the way of development. While the majority of people with disabilities live independently, some whose problems are severe and chronic need either temporary or long-term help from society.

Over the past 15 years, both society's view of disabled people and the help offered to individuals and their families have changed. Community programs have grown to provide alternatives to placement in state hospitals. Minnesota statutes and court decisions document the changes and show a long history of concern for vulnerable people.

New principles call for more normal and less "institutional" program settings, integration with nonhandicapped people, and client participation in decisions about their lives. These changes were the result of many events including the growing concern for individual rights, the effectiveness of advocacy groups, and the successes of disabled people in community programs.

People with developmental disabilities live, learn, and work in Minnesota communities with support from special programs and generic or existing services used by everyone. For developmentally disabled children, the first choice for a home is with their own families. The help families need is varied, often short term, and far less costly than institutional care. In-home supports help keep families together. Minnesota's Family Subsidy Program serves 200 families and has a long waiting list.

Preferences for homes in the community are that they be family-sized, close to transportation and services, and provide individual attention to residents. In Minnesota, the more independent adult clients live in their own homes or are in Semi-Independent Living Services (SILS) where they learn skills they need to care for themselves. A few hundred adults and children live with foster families. Over 4,500 people live in community Intermediate Care Facilities for the Mentally Retarded (ICF/MR). Residents of ICF/MRs must have a plan of care and 24-hour supervision. Estimates are that from 200 to 1,000 people in ICF/MRs are ready for less-restrictive alternatives like foster care or SILS. A barrier to people's movement is that more restrictive options like ICF/MRs have more stable, less limited funding.

Day programs for people with disabilities include limited pre-school offerings, special education for ages 4 to 21, and for adults, developmental achievement centers, work activity, sheltered work, and regular employment. (Developmental Disabilities and Public Policy: A Review for Policymakers)

1.4 What Is the "Developmental Disabilities Basic State Grant Program"?

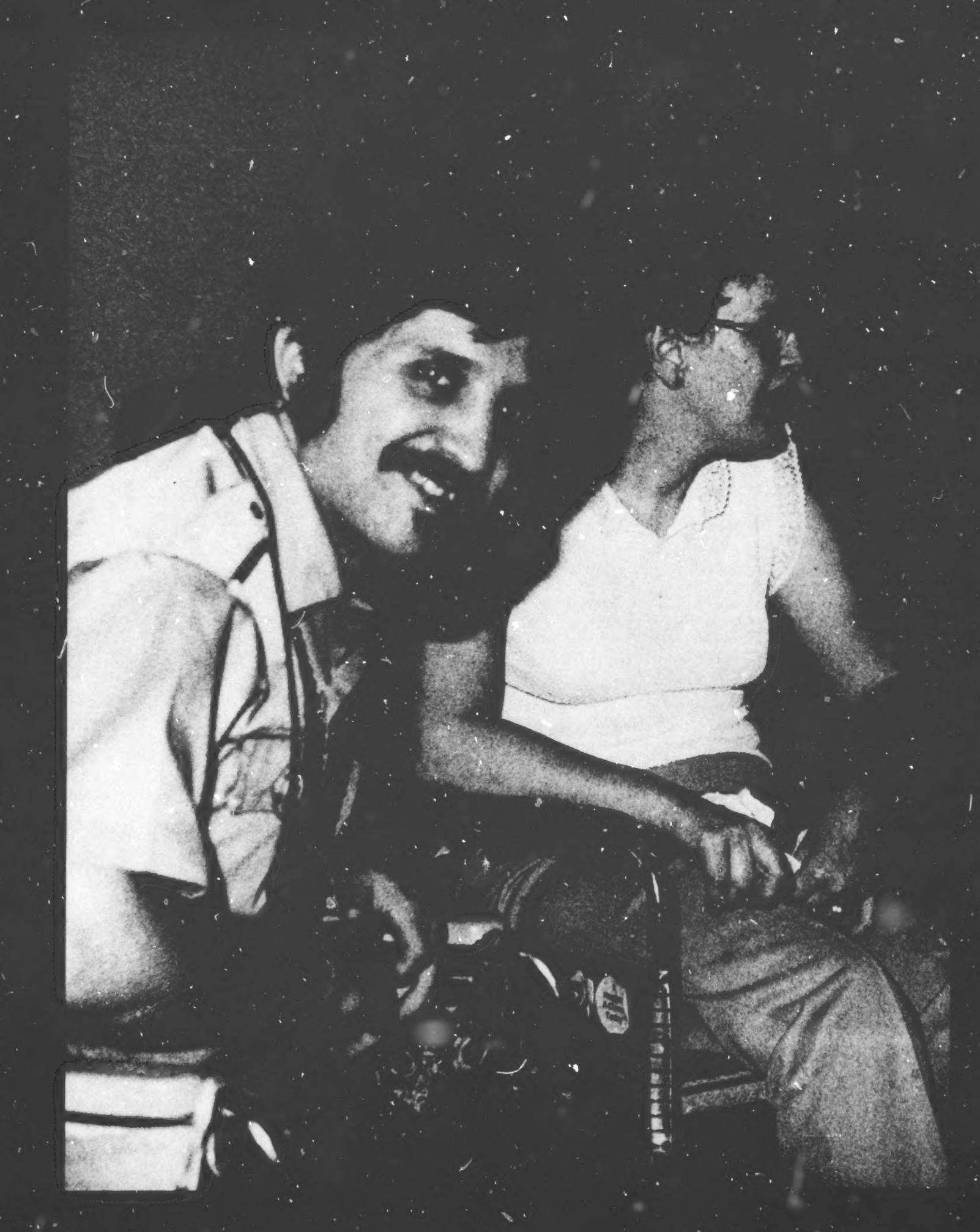
> The Developmental Disabilities Basic State Grant Program is a federally-assisted State program designed to assure ". . .that persons with developmental disabilities receive the care, treatment, and other services necessary to enable them to achieve their maximum potential through a system which coordinates, monitors, plans, and evaluates those services. . ." (Section 101(b) (1))

The specific purposes of the Basic Grant Program, as outlined in Section 101(b)(2) of Public Law 95-602, are as follows:

> "(A) to assist in the provision of comprehensive services to persons with developmental disabilities, with priority to those persons whose needs cannot be covered or otherwise met under the Education for All Handicapped Children Act, the Rehabilitation Act of 1973, or other health, education, or welfare programs;
>
> "(B) to assist States in appropriate planning activities; and
>
> "(C) to make grants to States and public and private, non-profit agencies to establish model programs, to demonstrate innovative habilitation techniques, and to train professional and para-professional personnel with respect to providing services to persons with developmental disabilities. . ."

The program works closely with the State Protection and Advocacy Agency " . . to ensure the protection of the legal and human rights of persons with developmental disabilities." (Section 101(b)(1))

In Minnesota, the State Protection and Advocacy Agency is the Minneapolis Legal Aid Society, Legal Advocacy Project for Developmentally Disabled People.



SECTION 2:

The Governor's Planning Council on Developmental Disabilities

2.1
What is the Governor's Planning Council on Developmental Disabilities?

The Minnesota Governor's Planning Council on Developmental Disabilities is a planning body composed of 27 members including persons with developmental disabilities and their families; and representatives of the principal state agencies, higher education training facilities, local agencies, and nongovernmental agencies and groups concerned with services to persons with develomental disabilities. At least 50 percent of the Council membership must consist of persons with developmental disabilities or parents or guardians of such persons. Of that 50 percent, one-third must be persons with developmental disabilities and another one-third must be immediate relatives or guardians of persons with mentally impairing developmental disabilities. At least one individual must be an immediate relative or guardian of an institutionalized person with a developmental disability.

Members are appointed by the Governor for three-year terms with a maximum of two terms.

The Council is charged with supervising the development of a three year state plan describing the quality, extent, and scope of needed services being provided or to be provided, to persons with developmental disabilities; to monitor and evaluate the implementation of the state plan; and to review state services plans for the developmentally disabled. (Executive Order 83-16)

2.2
Who Are the Council Members?

Mr. Richard Nelson, M.D., Chair
Mr. Rick Amado, Ph.D.
Mr. Doug Butler
Mr. Robert DeBoer
Mr. Robert Deneen
Mr. Eric Errickson, Ph.D.
Ms. Mary Rae Freeberg
Mr. John Groos
Ms. Bonnie Hammel
Ms. Virginia Hanel
Ms. Mary Hinze
Ms. Jan Jenkins
Mr. Robert Johnson
Ms. Helmi Lammi
Ms. Margaret Lindstrom
Ms. Virginia Marolt
Ms. Nancy Okinow
Ms. Barbara Pihlgren
Ms. Ruth Rafteseth
Mr. Felipe Ramirez
Ms. Elaine Saline
Mr. Glenn Samuelson
Ms. Sharon Shapiro
Mr. Kurt Strom
Ms. Kathleen Sturre
Mr. Marvin Tritz
Mr. Larry Wefring

SECTION 3:

The Administering Agency for the Developmental Disabilities Program

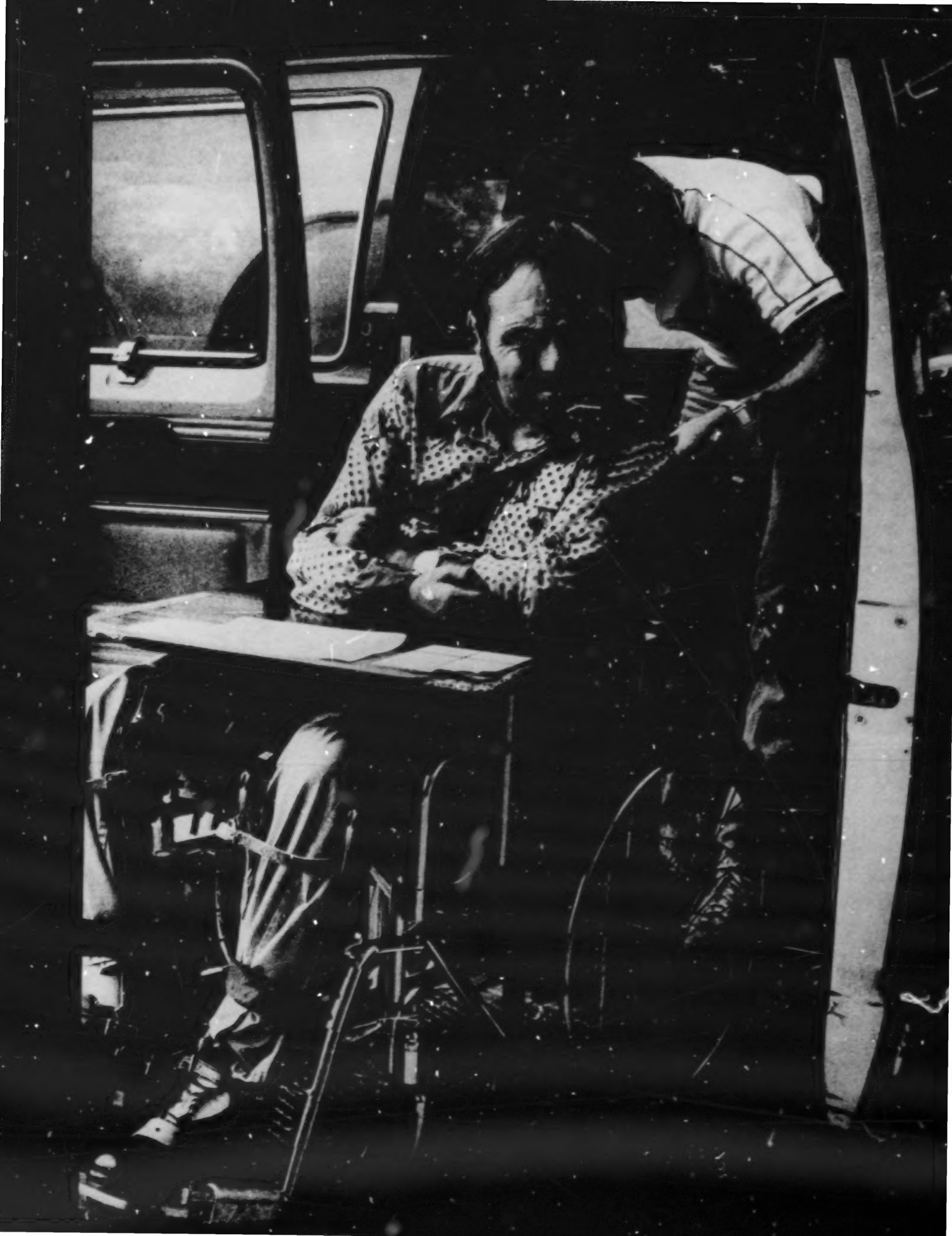
3.1 What Is the Designated State Administering Agency?

The designated state administering agency is the Minnesota State Planning Agency. The Developmental Disabilities Program, in the Human Services Division, is responsible for providing staff and other administrative assistance to the Governor's Planning Council on Developmental Disabilities.

3.2 Who Are the Staff Members?

The administering agency staff includes:

Ms. Colleen Wieck, Ph.D.	Director
Ms. Michelle Casey	Policy analysis
Ms. Audrey Clasemann	Office management
Mr. Bill Clausen	Policy analysis
Ms. RoseAnn Faber	Legislative activities/review and comment
Mr. Ron Kaliszewski	Grants administration
Mr. Scott Nagel	Statistical analysis
Mr. Pete Schmitz	Grant fiscal analysis
Mr. Roger Strand	Public information/training



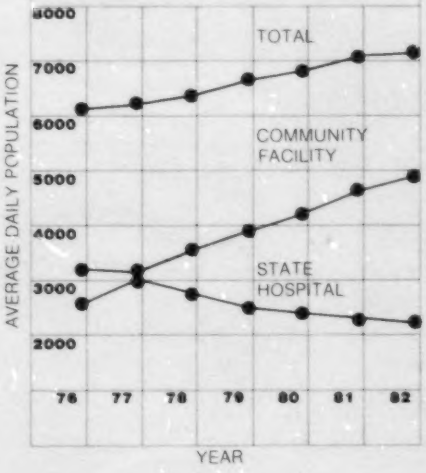
SECTION 4:

The State Context

4.1
What Is the Environment in Which the Developmental Disabilities Program Operates in Minnesota?

Several factors affect decision making regarding services for developmentally disabled people in Minnesota. These factors include: a) the severe budget crises which the state has suffered during the past few years; b) the *Welsch v. Levine* Consent Decree, which mandates changes in the service system for mentally retarded people by 1987; c) the maturity of Minnesota's service system; and d) the decentralization of responsibility for provision of social services to counties under the Community Social Services Act (CSSA) of 1980.

Mentally Retarded Persons in State Hospitals and Community Residential Facilities 1976-1982



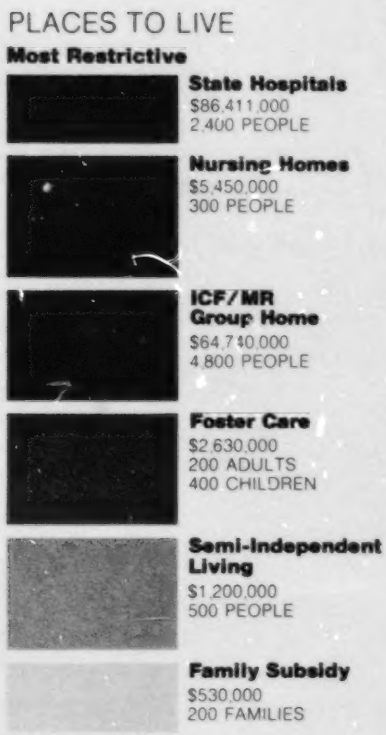
While many states have experienced fiscal crises during the past few years, Minnesota's budgetary problems have been generally acknowledged to be among the worst in the country. Between August 1980 and November 1982, Minnesota experienced five revenue shortfalls totaling over two billion dollars. A recent report from the Center for Urban and Regional Affairs, University of Minnesota, entitled *Fiscal Constraints on Minnesota—Impacts and Policies: Economic Conditions and Changing Government Policies* summarized the effect of these revenue shortfalls on the delivery of human services in the state. The report notes that virtually all areas of the state's budget, including health and welfare, have been cut. Reductions in aids to local governments have affected human services significantly:

> Counties in Minnesota dropped a significant number of clients from their income maintenance and social service programs in response to changes in eligibility criteria at both the state and federal levels. The human services portion of county budgets seems to be the hardest hit by aid cutbacks. Local revenue was increased by raising the property tax to or near the state-mandated levy limit for human services in almost every county in the state. In fact, a number of counties violated the limits applied to human services. (p. 113).

The second factor affecting services for developmentally disabled people is the *Welsch v. Levine* Consent Decree, which was signed in U.S. District Court in September 1980. The Consent Decree requires the State of Minnesota to substantially reduce the overall population of mentally retarded persons residing in state hospitals by 1987. Provisions of the Consent Decree address the need for improvement of conditions in state hospitals and the development of community-based services for mentally retarded persons who are discharged from state hospitals.

The Minnesota Department of Public Welfare addressed the mandates of the Consent Decree in a *Six Year Plan of Action* whose major goal was:

> the deliberate and systematic reduction of the number of mentally retarded people living in the state hospitals to not more than 1,850 by June 30, 1987; and the simultaneous development of sufficient and appropriate community-based residential and day program services in a manner that is as cost efficient and program effective as possible.
> (Six Year Plan of Action, 1981, p. 1)



This goal has continued to guide service provision in Minnesota. However, the objectives and means of implementation in the *Six Year Plan* were recently revised in a Department of Public Welfare system redesign plan. The actions recommended in the plan include:

- applying for a Medical Assistance waiver under Section 1915(c) of Title XIX of the Social Security Act to cover an array of services for current residents of community ICF/MRs and state hospitals, and those persons determined to be at risk of institutional placement. The services to be covered would be case management, family training and support, developmental training homes, supervised living arrangements, semi-independent living services, and adult day habilitative services;
- establishing a cap on certified ICF/MR beds in the state, including both beds in community-based residential facilities and state hospitals, and restricting future development of ICF/MR beds to areas of high need, for specific populations, and in relation to reductions in use of existing facilities;
- establishing statewide admission criteria for state hospitals and other components of the service system; using county level screening teams to monitor use of services; and
- consolidating state hospital programs for the mentally retarded.
  (A Proposed Plan of Action for the Redesign of the Scope and Funding of Services for the Mentally Retarded in Minnesota, Executive Summary)

During the 1983 Minnesota legislative session, legislation was passed and signed which authorizes the Department of Public Welfare to implement elements of the proposed plan of action, including application for a Medical Assistance Waiver. The effects of the proposed redesign will be monitored. The impact of the changes on the developmental disabilities service system will depend on whether Minnesota's waiver request is approved and how the waiver is implemented. One potential effect may be to penalize parents who have kept their child at home until adulthood and will now have to wait longer to place the child in a residential facility.

The Department of Public Welfare's proposed changes reflect the importance of the third factor which affects service delivery for developmentally disabled people—the maturity of Minnesota's service system. Minnesota was an early leader in the development of community-based ICF/MRs, and the number of these facilities in the state has continued to grow rapidly. According to a recent report by the Office of the Legislative Auditor, Minnesota's population in community-based ICF/MRs is, on a per capita basis, larger than that of any other state.
(Legislative Audit Commission, February 11, 1983, p. 12)

The Legislative Audit report criticizes the state's heavy reliance on residential facilities. It concludes that overreliance on the ICF/MR model has been very costly because of the state's long-term investment in property and buildings. The Audit report further notes that "alternatives to ICF/MR care, such as semi-independent living services (SILS) and foster care, lack stable funding and are not well-developed." (p. 77).

The fourth factor affecting developmental disabilities services is the decentralization of responsibility for social services. The passage of the Community Social Services Act (CSSA) in 1979 transferred responsibility for planning and funding a range of social services from the state to the county level. Under the CSSA, county boards are responsible for providing services to seven mandated groups of persons, including mentally retarded persons. Funds distributed by the counties under the act include federal Title XX dollars and state aids. The transfer of responsibility for social services coincided with reductions in federal and state expenditures and the development of considerable budgetary problems for some counties. As a consequence, decentralization has resulted in substantial variations in funding for community services, especially day program services for developmentally disabled people.

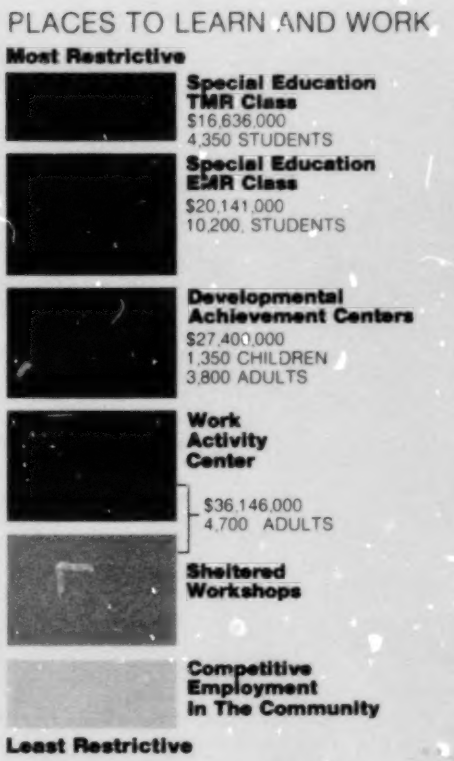
4.1.1 Issues and Concerns which Influence Services for People with Developmental Disabilities

The major long-range issues which the Council is addressing are: a) community integration of all developmentally disabled people, and b) removal of fiscal disincentives which discourage placement in the least restrictive environment.

The Council recognizes that Minnesota must continue to make major changes in the way services are provided if we are to fully accomplish the community integration of all developmentally disabled people. The Council has adopted the position that:

- services should be provided at the local level so that all disabled persons can be served in community-based programs regardless of the severity of their disability;
- local programs should adopt a "zero reject" model of service provision;
- all unnecessary admissions and readmissions to institutions should be prevented;
- developmentally disabled persons should have access to generic resources and settings, whenever those resources and settings are appropriate to meet the individual's needs;
- communities should develop a full range of services to meet the developmental and human needs of all developmentally disabled persons;
- support should be provided to families to assist them in meeting the needs of developmentally disabled family members; and
- individualized program plans should be used to develop the skills of developmentally disabled people so that they may participate in and contribute to their community.

(adapted from Minnesota Governor's Planning Council on Developmental Disabilities, Position Statement on Service Provision to Developmentally Disabled People, 1982)



Work is a vital part of the lives of a great majority of persons with developmental disabilities. It is crucial that planning efforts focus attention on maintaining existing services and programs lest needed employment training and work opportunities be lost in these times of diminishing resources.

(Testimony, Governor's Council on Developmental Disabilities Public Hearing, May 1982)

The removal of fiscal disincentives for placement in the least restrictive environment has become an increasingly important issue as budget cutbacks have led to overall reductions in human services dollars. The Council believes that it is possible to both contain costs and provide developmentally disabled people with opportunities to live, work, and learn in the least restrictive environment. However, current funding patterns in Minnesota favor the most expensive and most restrictive settings. Less restrictive alternatives frequently have unstable funding and cost more local dollars than more restrictive options. The Council views the issue of fiscal disincentives as a critical one which must be addressed if developmentally disabled persons are to receive the most appropriate and cost-effective services.

4.1.2 The Scope of Services for Persons with Developmental Disabilities

Services for persons with developmental disabilities are located in several state departments. The following describes the scope and types of services as required by the State Plan Guidelines. These are direct services only; regulatory functions are not included.

Department of Economic Security, Division of Vocational Rehabilitation

Agency Purpose: The purpose of the Department of Economic Security is to develop, implement, and coordinate employment and income policies and programs for the State of Minnesota. It is the state's principal agency for employment and job training programs, vocational rehabilitation programs, and the unemployment insurance program.

For those whose physical, mental, or emotional disabilities are a handicap to employment, the department provides an array of services including training and placement in competitive or sheltered work. The department serves low-income people within the state by operating programs which help the poor obtain emergency energy support, weatherize their homes, and become more involved in decisions that affect their lives.

The Vocational Rehabilitation Division provides client services through 40 statewide offices. The primary objective of the Vocational Rehabilitation Division is to prepare physically, mentally, and emotionally handicapped persons to engage in gainful employment to the extent of their abilities. Each client is assigned to a counselor and receives counseling and guidance based on a jointly developed individualized written rehabilitation plan. The division has cooperative arrangements with public schools, state hospitals for the mentally ill and mentally retarded, and the state correctional institutions to help provide broader and more timely vocational rehabilitation services. Its employment dimension has two aspects: facilitating the transition into the competitive job market for those with potential for gainful employment and providing employment opportunities in sheltered workshops for clients who are too severely disabled to function competitively in the work force.

The Vocational Rehabilitation Division has a second objective of training severely handicapped individuals to live independently. These persons may not be able to become employable; but through special training and modification of a living site, they can gain a measure of independence and become less of a financial burden on the state.

In state fiscal year 1982, 4,586 persons were successfully rehabilitated; 6,067 were served in sheltered work facilities; 32,643 claims for Social Security benefits were processed; 1,436 assistance and information services were provided through the Regional Service Centers; and 1,003 persons received independent living services through three Independent Living Centers.

Clientele: This program serves persons with physical and mental disabilities who need special assistance in order to function at an appropriate level of independence in our economic society. The program's major efforts are directed toward: 1) those persons who can be competitively employed; 2) those who cannot attain competitive employment but can be productive in sheltered employment; and 3) those who need assistance in living independently, whether they are employed or not. The program emphasizes serving severely disabled persons in all disability groups. Many of these clients may require multiple services over an extended period of time and a portion may only achieve sheltered employment or work activity.

Department of Public Welfare, Bureau of Social Services

Program Purpose: The Social Services Bureau is responsible for a broad range of social services provided by a variety of public and private delivery systems. The target populations for whom such services are intended include the aged, blind, hearing impaired, vulnerable adults, families with children in danger of neglect or abuse, and children in substitute care.

The program develops plans, allocates and distributes funds, and directly provides services to achieve the following client-centered goals:

- Achieve or maintain economic self-support.
- Achieve or maintain self-sufficiency.
- Prevent or remedy neglect, abuse, or exploitation of children or adults unable to protect their own interests.
- Preserve, rehabilitate, or reunite families.
- Assure the appropriate use of institutional care and treatment.

Clientele: Agencies supervised include the 87 counties; 290 nutritional sites; 13 area agencies on aging; and 25 child-placing agencies. Clientele receiving services include 105,000 social service clients of county boards; over 10,000 older persons each day through the nutritional programs; 2,500 deaf and hearing impaired persons who receive counseling and case service management; 6,600 visually handicapped persons who receive vocational rehabilitation, personal adjustment and independent living services; and 8,000 blind and other physically handicapped persons who receive communications center services.

Department of Public Welfare, Bureau of Income Maintenance

Program Purpose: The income maintenance programs provide cash assistance, food stamps, and payments to providers of medical and health care services to and on behalf of needy citizens of the state. These cash assistance and medical payments exist to provide basic standards of living and enable low income citizens to have access to quality medical care for both acute and chronic health-related problems. Through this assistance, low income citizens have access to the basic necessities—food, clothing, shelter, and medical care—required by all persons.

In addition, the Income Maintenance Bureau provides the management support function of quality control review in Aid to Families With Dependent Children (AFDC), Food Stamps, and Medical Assistance; and reviews local agency management of the Food Stamp Program; and gathers necessary data to claim federal funds and complete a wide variety of internal management reports.

Through the program integrity activities, abuse and fraud by both recipients and providers of the Medicaid Program are contained.

Operation: State agency staff provide program guidelines to local agencies in the form of rules and policy which are designed to maximize federal funding while ensuring that the needs of low income citizens are met. In addition, state agency staff make payments to providers of medical and health services, as well as conduct postpayment audits to detect abuse and/or fraud by recipients and providers of the Medical Assistance Program and recipients of the cash assistance and Food Stamp programs. Local agency staff determine individual eligibility for all programs, make cash assistance payments, and issue food stamps. The major goal of the Income Maintenance Program is to provide the appropriate cash assistance, noncash benefits or medical benefits to all eligible citizens in an effective and efficient manner.

Clientele: The primary clientele of the Income Maintenance Program are the low income clients served by the program and the providers of medical and health care services who are paid by the Centralized Disbursement System.

Since most of the recipients of cash assistance are eligible for food stamps and all recipients of AFDC and MSA are eligible for MA, the same persons can be counted in several of these programs because the basic needs for food, clothing, shelter, and medical care are universal. The number of people requiring assistance and the cost of programs change in relation to the demographic changes, as well as changes in national and state economic conditions.

Low Income Citizens Served by Income Maintenance Programs Average Month, FY 1982:

Aid to Families with Dependent Children	138,485
General Assistance	8,510
Medical Assistance(MA)	134,906
General Assistance Medical Care (GAMC)	10,819
Minnesota Supplemental Aid (MSA)	10,202
Food Stamps(FS)	210,000
Catastrophic Health Expense Protection Program	213

Department of Public Welfare, Bureau of Mental Health

Program Purpose: This program exists to ensure that citizens who are mentally retarded, mentally ill, or chemically dependent receive humane care and appropriate treatment; that these services are provided at the most effective and accessible level; and that these services will help each person live as productive, independent, and normal a life as possible. The Mental Health Bureau has a responsibility to promote prevention of these disabilities, to identify needed services, and to aid in the development of needed programs and services by local agencies.

- The program offices for Mental Illness, Mental Retardation, and Chemical Dependency develop state plans, coordinate the delivery of services among state and local agencies, develop service standards for each disability, provide technical assistance to counties and service providers, administer certain categorical and federal block grant programs, monitor counties' and providers' compliance with standards, promote prevention services and evaluate the effectiveness of services.
- The Client Protection Office educates state and local agencies about the legal, civil, and human rights of clients, and investigates complaints about violations of these rights.
- The Residential Facilities Division supervises the operation of 8 state hospitals and 2 state nursing homes.

Clientele: The direct clientele of the Mental Health Bureau are the local social service agencies; county and human service boards; the Governor's office; the legislature; state agencies for Health, Corrections, Education, Economic Security and Planning; private service providers; and advocacy groups.

In addition to this client group, this program has two other kinds of direct service clients: mentally retarded people who are under state guardianship or conservatorship, and people receiving care and treatment in state hospitals and nursing homes. Indirect clientele include all Minnesota citizens with problems of mental retardation, mental illness or chemical dependency.

Department of Health, Maternal and Child Health Services

Program Purpose: The purpose of this activity is to improve the health status of children and youth, women and their families by providing technical and financial support services to local community health agencies, schools, and voluntary organizations. Services include program planning, goal setting, technical consultation, professional education and training, and grants for specialized purposes. A large portion of the budget is for the purchase of supplemental foods for women, infants, and children. The following activities are generally coordinated with one another at the service delivery site so that comprehensive maternal and child health services are provided to individuals.

The Women, Infants, and Children (WIC) activity, funded by the U.S. Department of Agriculture, provides nutritious supplemental foods and nutrition education to mothers, infants, and children to age five years who are at nutritional risk and enrolled in local WIC programs. The state staff provide standards, technical support, grants management, and monitoring for local WIC agencies so that federal requirements are met and quality is

assured. The state staff manages an automated financial management system for issuance and reconcilation of vouchers issued to program participants for purchase of foods at authorized grocery stores, drug stores and dairies.

The Human Genetics activity provides counseling for patients and family members with known or suspected genetic diseases, consultation, education, and diagnostic support to physicians and other health professionals, and detection of metabolic diseases in newborns through screening. These services help persons manage genetic diseases and make informed decisions on future child-bearing.

The Child Health Screening activity promotes and provides technical support for accessible high quality health and developmental screening for all children in the state. The services are supported by combined state and federal funds provided through the state departments of Health, Education, and Welfare, and administered in communities.

The purpose of the Hearing and Vision Conservation activity is to assure that children with hearing or vision problems are identified at the earliest possible time and arrangements made for treatment and remediation. This is accomplished by local and regional personnel using state guidelines, technical consultation and training, and equipment calibration to assure quality service and cost efficiency. The staff provides public education concerning primary and secondary prevention of hearing and vision problems.

Personnel in the Family Planning activity work with local public and voluntary agencies to develop quality family planning services and prenatal, postnatal, and perinatal services which increase the potential for healthy pregnancies and newborns. The activity administers family planning grants to community agencies, sets standards, and provides technical support services to community programs. A particular focus of attention is the unplanned adolescent pregnancy.

Department of Health, Services for Children with Handicaps

Program Purpose: The purpose of Services for Children with Handicaps is to assure the identification, diagnosis, and treatment of children with handicapping conditions caused by birth defects, congenital cardiac lesions, hereditary disease, or chronic diseases such as diabetes, cystic fibrosis, or cancer. Services for Children with Handicaps (SCH) provides 300 field clinics serving 87 counties and arranges for diagnostic and treatment services in medical centers and/or further health and social services necessary for the habilitation of about 12,000 children known to SCH. SCH offers leadership in establishing guidelines and serves as a model for a system of multispecialty care for children with handicaps. This program also manages the Supplemental Security Income—Disabled Children's Program which was serving 1,382 children as of March 1983.

Department of Education, Special and Compensatory Education

Program Purpose: The Special and Compensatory activity facilitates the delivery of educational services to 5 unique populations of preschool, elementary, secondary students and adults for whom "regular" curricular offerings are either inadequate or inappropriate. Services are provided through the following components: a) Special Education for Handicapped Children; b) Title I/Chapter 1 for the Education of Disadvantaged Children; c) Title I/Chapter 1 Migrant Education; d) Indian Education; e) Education for Limited English Proficient (LEP); and f) Monitoring and Compliance. This activity is required by state and/or federal statute, regulation, and rule.

Major Objectives:

1. To establish procedures, recommend rules and statutes, and clarify standards so that consistent and appropriate educational opportunities are available to eligible persons with unique educational needs.
2. To enforce minimum standards for the operation of existing programs and to assist in the implementation of new programs to be operated by public schools and other agencies so that every eligible person with unique educational needs has an equal opportunity to receive an appropriate education.
3. To assist the Department in the acquisition of resources so that other state agencies and public school districts have available to them the human and fiscal resources to provide appropriate education opportunities to eligible persons with unique educational needs.
4. To disburse state and federal funds for the education of eligible persons with unique educational needs according to existing rules and statutes so that all eligible recipient agencies receive funds for which requirements have been met.
5. To directly provide education opportunities for eligible persons with unique educational needs to supplement the range of opportunities available through other agencies and school districts.
6. To provide training and technical assistance to persons and groups serving unique populations and to disseminate information to Department staff, the Governor's Office, State Legislature, other state and federal agencies, Indian tribes, public school districts, parents, and the general public so that the unique educational needs of eligible persons are understood and opportunities for them are improved.
7. To develop, implement, and maintain an evaluation system to determine the effectiveness and efficiency of educational opportunities provided for eligible persons with unique educational needs.

(The above narrative summaries of state agency operations were adapted primarily from the *Governor's Proposed Biennial Budget, FY 1983-1984).*

4.2
What Are the Council's Major Concerns during the Three-Year Plan Period?

The Council's selection of major concerns for the three-year plan period 1984-86 was shaped by several factors, including: awareness of federally mandated responsibilities under P.L. 95-602; assessment of statewide needs in each priority area; final selection of a priority area; and recognition of decision making processes which affect service delivery in the chosen priority area.

The Quantity and Quality of Day Programs

The Council's primary area of concern is the quantity and quality of day programs throughout the state. Specific concerns in this area include:

- the lack of a stable funding base for day programs;
- cuts in day program services, including reductions in days and hours of service and client demissions due to fiscal constraints;
- limited capacity in existing day programs, wide variations in program availability and levels of service across the state, waiting lists for services, lack of movement from developmental achievement centers (DACs) to less restrictive settings.
- day programs lack the capacity to deal with special needs clients (severely and profoundly retarded, multiply handicapped, individuals with behavior problems); insufficient staff training is a factor here;
- procuring sufficient amounts of appropriate work for prevocational and vocational programming has become increasingly difficult; and
- day programs lack adequate minimum standards because of outdated licensing and programmatic rules; there is inadequate monitoring of programs.

There are considerable data to support the Council's concerns in this area. Various studies, a public hearing, and legal proceedings have documented problems in the day services area.

Studies of day program services conducted by the Developmental Disabilities Program during the past two years include statewide surveys of developmental achievement center services and sheltered workshop services. These studies are: *Policy Analysis Series Paper No. 6: The Financial Status of Minnesota Developmental Achievement Centers: 1980-1982; Policy Analysis Series Paper No. 7: The Program Status of Minnesota Developmental Achievement Centers: 1980-1982; Policy Analysis Series Paper No. 8; The Client Status of Minnesota Developmental Achievement Centers: 1980-1982; Policy Analysis Series Paper No. 9: Summary of Issues, Programs, and Clients in Minnesota Developmental Achievement Centers: 1980-1982; Policy Analysis Series Paper No. 16: A Statewide Summary of Sheltered Employment Programs: 1980-1983; and Policy Analysis Series Paper No. 17: The Financial, Client, and Program Status of Minnesota Developmental Achievement Centers: 1982.*

These studies described day program services, identified major system issues, and discussed potential solutions to the problems of the day service system. The Council's public hearing in May 1982 (which is described in

Section 4.3.2) also provided evidence supporting the Council's concern in this area. The priority area of nonvocational social development services ranked first in terms of comment and/or priority designation by witnesses at the hearing.

Additional supporting evidence for designation of day programs as a major area of concern for the Council comes from legal proceedings on the issue of providing appropriate day services. During the past two years, several appeals regarding service reductions have been filed with the Minnesota Department of Public Welfare, and there have been both compliance hearings for the *Welsch* Consent Decree and a Minnesota Supreme Court case relating to provision of DAC services.

4.3
What Are "Priority Service Areas"?

The Federal Developmental Disabilities Act requires each state to assess the service needs of all developmentally disabled citizens, with special emphasis on four service areas identified in the legislation as requiring special consideration. These four areas are listed and defined in paragraph 4.3.1.

The Act further requires each State Developmental Disabilities Program to commit at least 65 percent of the Federal allotment to "service activities" in one or, at the State's option, two targeted services areas. These targeted areas are referred to as the "State's Priority Service Areas." (The number of "priority service areas" which may be addressed varies dependent on the level of Federal funding. If Federal program funding exceeds $60,000,000 nationally, then States may name a third priority service area.)

If a State elects to name only one "State Priority Service Area," then the State must name one of the four service areas identified by the Federal legislation as requiring special consideration. If the State opts to select two "State Priority Service Areas," the additional service area may be any service area that has been documented as needed to enhance services to citizens with developmental disabilities.

The process and justification for selection of the State's priority service area(s) is provided in paragraph 4.3.2. The current priority service areas are named in paragraph 4.3.3.

4.3.1
The Federal Definitions of "Priority Service Areas" and the Elements of Those Services as Operationalized in Minnesota

Case Management

Services which will assist persons with developmental disabilities in gaining access to needed social, medical, educational, and other services; includes follow-along services which ensure a continuing relationship lifelong if necessary, between a provider and a person with developmental disabilities and the person's immediate relatives or guardians; includes coordination services which provide support, access to and coordination of other services, information on programs and services and monitoring of progress. (Section 102(8) (C)(i)(ii)).

I've known so many children who at birth had decent APGAR scores, normal Denvers and then at 18 months, the decline begins to show. It makes its first appearance as anxiety, impulsivity, and clinging to strangers. By about 4 years of age, they test as developmentally disabled—etiology unknown. Certainly, there are other factors—sometimes physical and verbal abuse, sexual abuse, poor nutrition, incessant health problems like ear infections, flu, bronchitis, red-eye—but the operant mechanism, the common denominator as . . . studies have shown, is neglect.

(Testimony, Governor's Council on Developmental Disabilities Public Hearing, May 1982)

Elements of Case Management Services in Minnesota: In Minnesota's county-based social service delivery system, primary responsibility for providing case management services to developmentally disabled people rests with county social service agencies. The Community Social Services Act (CSSA) established county responsibility for the planning and provision of community social services to seven mandated groups of people including mentally retarded people "who are unable to provide for their own needs or to independently engage in ordinary community activities."

Under the CSSA, county board authority includes contracting for or directly providing: 1) an assessment of the needs of each person applying for services which estimates the nature and extent of the problem to be addressed and identifies the means available to meet the person's need for services; 2) protection for safety, health, or well-being by providing services directed at the goal of attaining the highest level of independent functioning appropriate to the individual preferably without removing those persons from their homes; 3) a means of facilitating access of physically handicapped or impaired persons to services appropriate to their needs. (MINN. STAT. § 256E.08, Subd. 1).

Minnesota Department of Welfare Rule 185 further defines county case management responsibilities with regard to mentally retarded people. The rule defines the purpose of case management as planning for the provision of appropriate services, and ensuring the delivery of such services. Case management services which local social service agencies are responsible for include diagnosis, assessment of client needs, development and implementation of the individual service plan, and evaluation services. Both the counties and the state may have additional case management responsibilities for clients receiving waivered services pending implementation of the recently passed Omnibus Mental Retardation Act.

Child Development Services

Services which will assist in the prevention, identification, and alleviation of developmental disabilities in children, and includes early intervention, counseling and training of parents, early identification and diagnosis and evaluation. (Section 102(8)(D)(i)(ii)(iii)(iv))

Elements of Child Development Services in Minnesota:

- *Early Identification, Diagnosis, and Evaluation Services:* Statewide, there are three comprehensive child screening programs whose purpose is the early identification of developmental and physical problems. These programs are Early and Periodic Screening (EPS), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and PreSchool Screening (PSS). They are administered by the Minnesota Departments of Health, Welfare, and Education, respectively, and maintain a shared reporting system.

  Services for Children with Handicaps (SCH) is an additional statewide resource for the identification, diagnosis, and treatment of children with handicapping conditions. The SCH program provides field clinics and arranges for diagnostic and treatment services in medical centers.

In addition to these statewide resources, private physicians, clinics, hospitals, public health agencies, and rehabilitation centers do screening and diagnosis of children with developmental disabilities.

- *Early Intervention Services:* A statewide system of developmental achievement center (DAC) programs provide home-based and in-center infant and preschool programs for developmentally disabled/delayed children. Some preschoolers also participate in developmental programs in public schools, Head Start programs, nursery schools, and day care programs. DAC programs, schools, and health care facilities provide therapeutic services for children. Parent counseling and training services are provided by DACs, advocacy organizations, and community social service agencies.

Services to special needs children from birth through age three are currently being delivered through a complex, loose network of service providers from Health, Education and Welfare . . . Because most of the services are not mandated, the availability of services varies from coordinated, comprehensive services to no services from one community to the next.

(Testimony, Governor's Council on Developmental Disabilities Public Hearing, May 1982)

Alternative Community Living Arrangement Services

Services which will assist persons with developmental disabilities in maintaining suitable residential arrangements in the community, including in-house services (such as personal aides and attendants and other domestic assistance and supportive services), family support services, foster care services, group living services, respite care, and staff training, placement, and maintenance services. (Section 102 (8)(E))

Elements of Alternative Community Living Arrangement Services in Minnesota: In Minnesota, the range of alternative community living arrangement services includes:

- *In-Home Family Support Services:* Includes the provision of services such as homemaking assistance, respite care, parent training, and support groups to families with developmentally disabled members. Sources of funding include the Minnesota Family Subsidy Program, county human services boards, and advocacy groups.

The family subsidy program is perhaps one of the most cost effective means of serving developmentally disabled children, yet it is not available to all who might use it within the state at this time.

(Testimony, Governor's Council on Developmental Disabilities Public Hearing, May 1982)

- *Semi-Independent Living Services (SILS):* The provision of SILS involves placement of adults in small units (2 to 4 people) where they are supervised by a licensed agency and provided with services based on need, including training in cooking, shopping, hygiene, and using public transportation. The purpose of SILS is to train for independence or to maintain individuals in semi-independence. SILS room and board are paid from the following sources: SSI, SSI/MSA, Social Security, Section 8 (HUD), GA, wages, food stamps, and combinations of these. In 1982, approximately 500 developmentally disabled adults were receiving semi-independent living services in Minnesota.
- *Foster Care Services:* Foster care services are provided for children who cannot live with their families and for adults who could benefit from a family setting. For child foster care, licensing standards require special provider training and experience and written individual programs. Foster care costs are paid in three ways: a) private pay by clients, b) SSI/MSA funds, and c) general assistance. In 1982, approximately 200 adults and 400 developmentally disabled children were receiving foster care services in Minnesota.

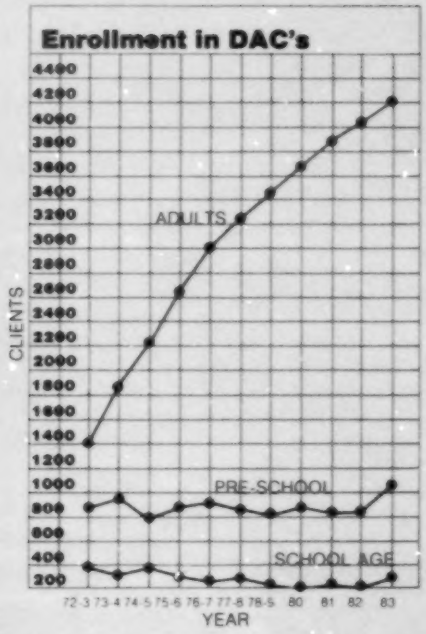
- *Group Living Services:* In Minnesota, group homes are usually licensed as Intermediate Care Facilities for the Mentally Retarded. Residents are provided with a plan of care with active treatment and 24-hour supervision. Most Minnesota group homes are licensed for 6 to 15 people; 44 are larger, while 6 exceed 100 beds. However, almost half (49.2 percent) of all ICF/MR residents live in facilities larger than 32 beds. Costs are paid by the federal government (52.2 percent), the state (43.0 percent), and the county (4.8 percent). As of January 1, 1983, 4,920 developmentally disabled persons were living in 313 licensed group homes in Minnesota.
- *Developmental Training Homes:* These homes are part of the proposed array of alternative services to be funded under the Medical Assistance waiver. As proposed, the homes will provide children and adolescents with special needs (medical care or behavioral problems) with habilitative services and adjunct services, including specialized training, respite, and support staff, in settings of up to three clients. The target group for these services will be children and adolescents who would otherwise require ICF/MR or state hospital placement.
- *Supported Living Arrangements:* These residential settings are also part of the proposed array of services to be funded under the waiver. The arrangements, as proposed, would involve maintaining up to three adult clients in a residential setting, using existing housing to the greatest extent possible.

Nonvocational Social Developmental Services

Services which will assist persons with developmental disabilities in performing daily living and work activities. (Section 102(8)(F))

Elements of Nonvocational Social Developmental Services in Minnesota: In Minnesota, the priority of nonvocational social development is most closely associated with the services performed by day programs. Day programs include the following programs:

- *Developmental Achievement Centers:* Nonwork- or prework-oriented programs focused upon social, daily living, recreation skills, and similar activities.
- *Work Activity Centers:* Included in the developmental or activities program are work activities for which consumers/participants receive pay.
- *Sheltered Workshops:* Work-oriented programs whose primary purpose is to secure current employment in a sheltered setting and/or future competitive employment (typically serves vocational rehabilitation clients and may provide evaluation, work adjustment, other vocational services, and external sheltered work positions).
- *Competitive Placement Programs:* Programs whose only purpose is to provide short-term training leading to placement in competitive employment and short-term follow-up after placement. (Programs providing remunerative work and placement services should be considered sheltered workshop programs.)



- *Competitive Employment:* Part-time or full-time work outside the programs listed above.

Each of these types of day programs has objectives which are compatible with the federal definition of "services that will assist people with developmental disabilities in performing daily living and work activities." These objectives include:

- *Increase Adaptive Behaviors:* Improve the skills that an individual uses to function competently and independently in community and home settings.
- *Maintain Health and Safety:* Safeguard the physical safety of individuals in the program.
- *Increase Integration:* Increase the time individuals spend in community in contact with other community members and in a manner typical of other members of the community.
- *Increase Independence:* Increase individual functioning within normal community activities without support.
- *Achieve Competitive Employment:* Prepare and place people in competitive employment.
- *Achieve Supported Employment:* Provide immediate remunerative work in a supported, job secure environment.
- *Increase Work Benefits:* Increase number of hours worked and wages earned.

The most critical problem with programs and services for the developmentally disabled is the need for an identified, stable funding base, especially for day programs and non-traditional residential alternatives.

(Testimony, Governor's Council on Developmental Disabilities Public Hearing, May 1982)

4.3.2 The Process by Which Minnesota's Priority Service Area is Selected

The process of identifying Minnesota's priority service area for this plan began in May 1982 when the Governor's Planning Council on Developmental Disabilities sponsored a two-day public forum to obtain input into the planning process. Invitations to provide testimony were mailed to over 40 organizations, and a general notice of the forum was printed in the *State Register.* The Council heard testimony from 33 people formally representing 29 regional coordinators, service agencies, providers, or advocacy groups. Testimony was solicited on three questions:

1. What is the current status of community services and programs germane to your organization?
2. What are the most critical problems or gaps in programs and services?
3. What recommendations or solutions do you propose to address the problems outlined?

. . . sheltered employment is facing reduced contract levels, shortened work weeks, and waiting lists of up to 1 1/2 years by potential clients for placement. Simulated work is becoming more prevalent as contracts become scarce.

(Testimony, Governor's Council on Developmental Disabilities Public Hearing, May 1982)

Public forum witnesses articulated a wide range of needs and made several suggestions for improving the service system for developmentally disabled people. The priority service areas ranked in the following order as they were singled out for comment and/or priority designation by the witnesses:

1. Nonvocational Social Development Services.
2. Child Development Services.
3. Alternative Community Living Arrangement Services.
4. Case Management.

A summary of the testimony was prepared and discussed during the Council's annual planning conference on June 9 and 10, 1982 (see Appendix). During the planning conference, Council members, staff, and consultants with expertise in each priority area met in small groups to discuss possible Council activities for fiscal years 1984-86 (supporting legislation, conducting policy studies, and providing grants for demonstration projects) in each area.

At the August 4, 1982, Council meeting, the proceedings of the June planning conference were reviewed and discussed. Council members voted on the priority service area for FY 1984-86. Nonvocational social development services was selected as their first priority.

The Grant Review Committee of the Council met on October 6, 1982, to discuss the grant priority area in more detail. Agreement was reached on some general guidelines for the grant program, including the number and size of grants, criteria for applicant eligibility, and target populations.

During the month of October, Council staff developed a draft RFP outlining the goals, outcomes, minimum activities, and evaluation criteria which would be expected in grant applications. This material was reviewed and modified at a Grant Review Committee meeting on November 3, 1982. Copies of the draft RFP were distributed to Council members, regional developmental disabilities coordinators, county social services staff, and other interested individuals for review and comment. These comments were summarized and discussed during the Council's December 1, 1982, meeting, and during the Grant Review Committee's all day work session on the grant program on December 8, 1982. In consultation with two experts in the area of day programming, Committee members and staff refined the content of the RFP.

The final RFP was distributed at public information meetings in Brainerd, St. Paul, and Owatonna in early February, 1983. Proposals were due in the Developmental Disabilities Office on April 29. Grant Review Committee members reviewed the proposals until May 18, when they met to recommend applications for funding. The Council then reviewed and acted on the Grant Review Committee recommendations at the June 1 meeting. The grant recipients' work is set to begin October 1, 1983.

4.3.3
Minnesota's Priority Service Area

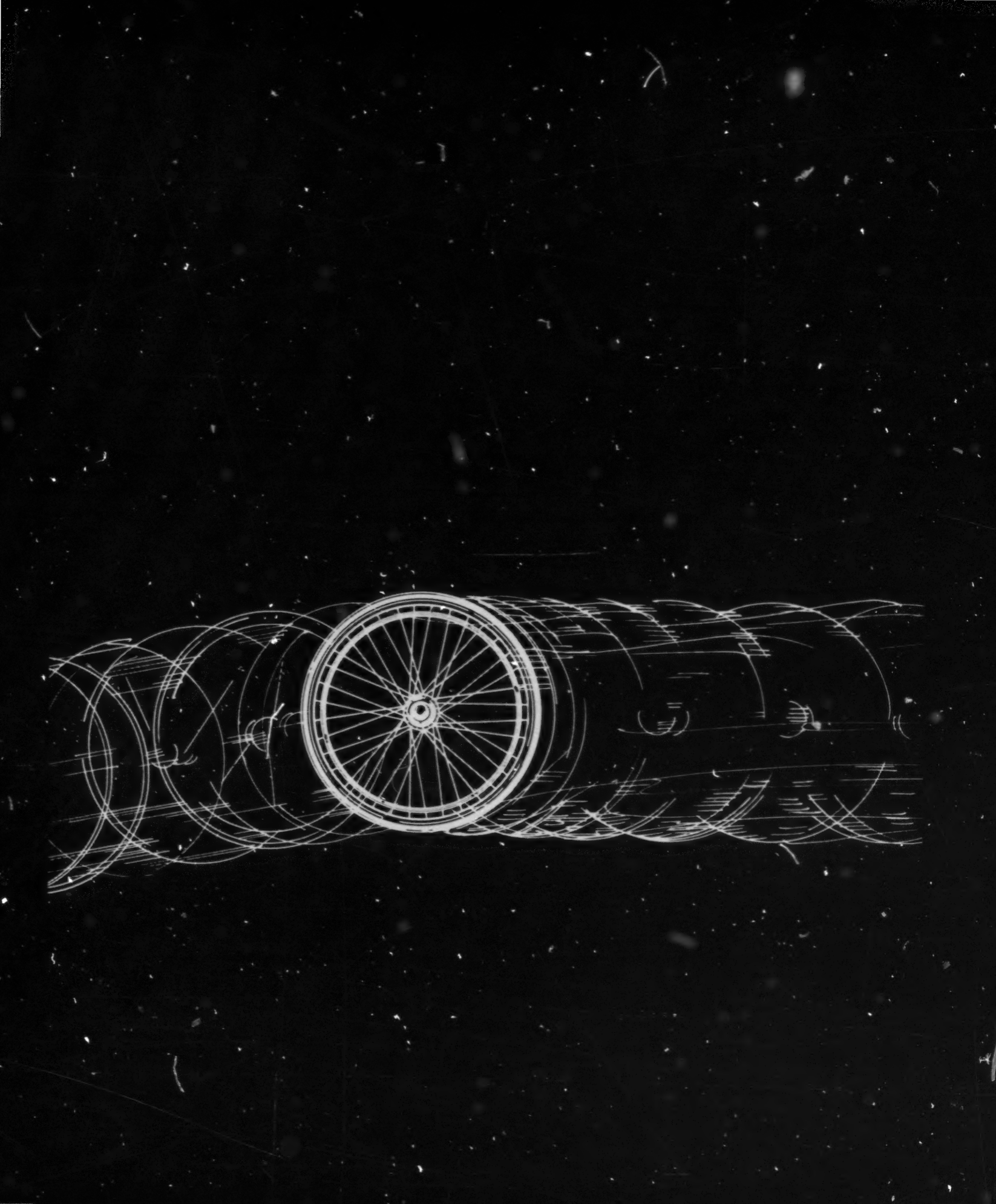
Through the process described in paragraph 4.3.2, Minnesota has selected the following priority service area for special emphasis during the next three years: Nonvocational Social Development Services.

The selection of this priority area was influenced by several factors, including:

- recognition that service cutbacks and unstable funding have made these services the weakest part of the community service system in Minnesota;
- concern over possible "reinstitutionalization in the community" with residential providers moving to provide in-house day programming;
- concern about the capacity of existing day programs to deal adequately with increasing numbers of deinstitutionalized individuals with special needs (behavior problems, severely and profoundly disabled); and
- awareness of the strong need for increased movement of clients into less restrictive, appropriate day programs.

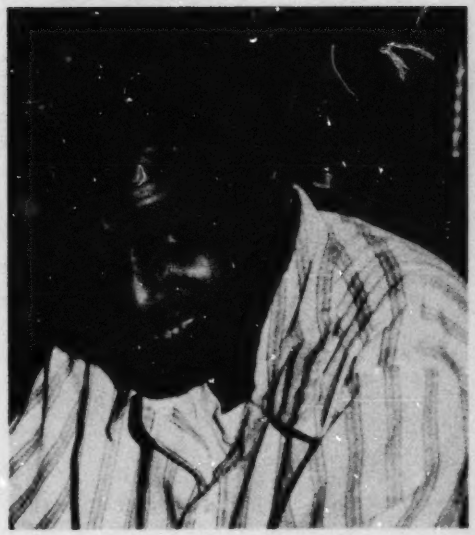
Lack of non-vocational social developmental services is frequently viewed as a major obstacle to client placement in community living arrangements and to the development of new residential programs.

(Testimony, Governor's Council on Developmental Disabilities Public Hearing, May 1982)



SECTION 5:

Goals, Objectives, and Funding



Section 5.1 describes the Council's goals, objectives, and funding allocations for the 65 percent of federal funds available to Minnesota for service activities in the priority service area of nonvocational social development services. In addition to these service activities, the Developmental Disabilities Program will also be carrying out several activities using the remaining federal funds as well as private sector funds from the McKnight Foundation. These activities are described briefly below.

Activities Using Federal Administrative Funds

- Carrying out policy studies related to developmental disabilities and conducting policy briefings with the legislature, counties, and the executive branch.

  This set of activities will consist of research and policy analysis activities such as conducting surveys and compiling data from secondary sources. Policy analysis papers on timely issues will be published and disseminated.

- Increasing public awareness about developmental disabilities through training, interagency meetings, public education, and technical assistance.

  The purpose of these activities is to promote understanding of the developmental disabilities programs throughout Minnesota. Activities will include: a) sponsoring and/or coordinating training activities on topics related to developmental disabilities; b) serving on interagency task forces of the Departments of Health, Welfare, and Education; c) publication of a periodic newsletter; d) making public speaking appearances or presentations about developmental disabilities; and e) providing technical assistance to a wide range or organizations as requested.

- Providing review and comment on federal and state plans, existing laws, proposed legislation, and administrative regulations.

  The purpose of these activities is to meet the mandates of Public Law 95-602 in order to influence policy through review and comment procedures. Activities will include: a) passage of resolutions by the Council on developmental disabilities issues; b) providing comment on proposed bills and rules relevant to developmental disabilities; c) attendance at legislative hearings; d) regular monitoring of *Federal* and *State Registers* and *Commerce Business Daily;* and e) review of state statutes related to developmental disabilities.

Activities Using McKnight Funds

The Developmental Disabilities Program is administering four programs using McKnight Foundation funds of $322,324 annually in 1982, 1983, and 1984. These four programs are a training program, a regional problem solving grant program, a problem-solving program for non-mentally retarded developmentally disabled people, and a technology research program.

- **McKnight Training Program**
  The purpose of this program is to offer management and direct care training to staff and board members of organizations which provide residential or day programs for developmentally disabled persons. Workshops are being offered throughout the state on a variety of organizational development, management, and staff training topics.
- **McKnight Regional Problem Solving Grant Program**
  This is a regranting program whose purpose is to fund regional projects that will bring about solutions to specific problems of a regional nature related to service delivery for developmentally disabled persons.
- **McKnight Problem Solving for Nonmentally Retarded Developmentally Disabled Persons**
  The purpose of this regranting program is to fund projects that will bring about solutions to specific problems related to service delivery for developmentally disabled persons who are not mentally retarded.
- **McKnight Technology Research**
  The purpose of this program is to do applied research into the use and potential of micro computer technology to assist developmentally disabled persons.

5.1
What Are the Council's Plan Year Objectives?

Council's Plan Year Objectives are identified in Table 5-1.

TABLE 5-1:
Plan Year Objectives
(Section 133(b)(2)(A))

1. **Goal:**
   To improve quantity and quality of day services for developmentally disabled persons, especially those who have behavioral problems, are severely or profoundly retarded, or are not mentally retarded.
2. **Three-Year Objective:** To expand capacity of existing programs and develop alternative services to meet client specific needs.
3. **Plan Year Objective:**
   To increase movement into least restrictive settings and to increase the number of appropriate placements for the target population.
4. **Plan Year Objective Activities:**
   - Training
   - Consultation
5. **Outcome Indicators:**
   Movement indicators (admissions, readmissions, transfers, etc.) toward net movement. Other criteria regarding outcomes of interventions in the areas of behavior problems and work.
6. **Projected Plan Year Funding:**
   Local $323,520.32 + Federal $425,465 = Total $748,985.32
7. **Priority Service Area:**
   Non-Vocational Social Developmental Services.
   - Model Service programs in the area
   - Activities to increase the capacity of institutions and agencies to provide services in the area
   - Training of personnel to provide services in the area
8. **Description Of Subgrantee or Implementing Agency:**
   Multiple counties, regional development commissions, and existing regional programs.
9. **Expected Effects On The Extent and Scope of Services:**
   Places emphasis on alternatives to existing system; places emphasis on underserved target population; places emphasis on multicounty cooperation.

TABLE 5-1:
Plan Year Objectives

(Section 133(b)(2)(A))

1. **Goal:**
   To improve quantity and quality of day services for developmentally disabled persons, especially those who have behavior problems, are severely or profoundly retarded, or are not mentally retarded.
2. **Three-Year Objective:**
   To influence state and local decision making regarding day programming and related issues.
3. **Plan Year Objective:**
   To develop background information and policy agenda; build coalition around day programming and related issues.
4. **Plan Year Objective Activities:**
   Publication of policy briefing book sequel.
5. **Outcome Indicators:**
   State and local decisions to expand capacity or develop alternative services. State and local funding decisions.
6. **Projected Plan Year Funding:**
   State $12,575 + Federal $50,300 = Total $62,875
7. **Priority Service Area:**
   Non-Vocational Social Development Services.
   - Model service programs in the area
   - Activities to increase the capacity of institutions and agencies and provide services in the area
   - Training of personnel to provide services in the area
8. **Description of Subgrantee or Implementing Agency:**
   University of Minnesota, Center for Educational Policy Studies or equivalent.
9. **Expected Effects On The Extent and Scope of Services:**
   The briefing book is used for several purposes such as training activities for boards of local providers and county commissioners.

5.2
What is the Developmental Disabilities Program's Projected Budget for FY 1984?

The Projected Expenditures for FY 1984 for the Developmental Disabilities Program are displayed in Table 5-2. The actual allotment and expenditures will be reported on the quarterly financial status report, on plan-year budget revisions, and at the close of the fiscal year as part of the "Annual Report."

5.3
Application Procedures for Subgrantees

The current grant cycle began in June 1982 with the selection of priorities by the Governor's Planning Council on Developmental Disabilities. The Grant Review Committee met to prepare a Request for Proposal (RFP); notice of the availability of the RFP was published in the Minnesota *State Register* of December 20, 1982. Notices were also mailed to each eligible applicant.

Two meetings, the dates of which were included in the notice, were held to explain and distribute the RFP. All potential applicants were invited. The first meeting was held in Brainerd, Minnesota, on February 1, 1983; the second was conducted in St. Paul, Minnesota, on February 3, 1983. A third meeting, scheduled for those who were unable to attend the second meeting due to inclement weather, was held in Owatonna, Minnesota, on February 17, 1983.

Applications were due by April 29, 1983. The Grant Review Committee members were mailed copies of each application, along with a description of the evaluation process and a score sheet. On May 18, 1983, the Grant Review Committee met to discuss the grant applications and to develop recommendations for action by the full Council.

On June 1, 1983, the full Governor's Planning Council on Developmental Disabilities met to act on the Grant Review Committee recommendations.

TABLE 5-2
Summary of Proposed Developmental Disabilities Expenditures

State of Minnesota
FY Ending September 30, 1984
Federal DD Fiscal Year Allotment $734,900 (Anticipated)

Allocations to State Agencies by Sources of Funds (Projected)
Designated State Agency: State Planning Agency

NON FEDERAL FUNDS				FEDERAL FUNDS	TOTAL
State	Local	Non Profit	Total		
$38,200.00	$381,428.32	$330,000.00	$749,628.32	$734,900.00	$1,484,528.32

Allocations to State Agencies by Purpose (Projected)
Designated State Agency: State Planning Agency

		PLANNING		ADMINISTRATION	PRIORITY SERVICE AREA	
	Total	Council	Other		Non Vocational	Other
Federal	$ 734,900.00	$100,000.00	$122,758.00	$36,377.00	$476,765.00	
Non Federal	749,628.32		30,000.00	38,200.00	336,095.32	$345,333.00
TOTAL	**$1,484,528.32**	**$100,000.00**	**$152,758.00**	**$74,577.00**	**$811,860.32**	**$345,333.00**

SECTION 6:

Assurances

6.1

The State assures that each designated State agency will make such reports, in such form and containing such information, as the Secretary (of Health and Human Services) may from time to time reasonably require, and keep such records and afford such access thereto as the Secretary finds necessary to verify such reports. (Section 133(b)(1)(C))

6.2

The State assures that it will maintain such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under Part C of Public Law 95-602. (Section 133(b)(1)(D))

6.3

The State assures that it will establish a method for the periodic evaluation of the plan's effectiveness in meeting the objectives set forth in the plan. (Section 133(b)(2)(D))

6.4

The State assures that funds paid to the State under Section 132 will be used to make a significant contribution toward strengthening services for persons with developmental disabilities in the various political subdivisions of the State. (Section 133(b)(3)(A))

6.5

The State assures that part of the funds (under Part C) will be made available to public or nonprofit private entities. (Section 133(b)(3)(B))

6.6

The State assures that funds paid to the State under Section 132 will be used to supplement and to increase the level of funds that would otherwise be made available for the purpose for which Federal funds are provided and not to supplant such non-Federal funds. (Section 133(b)(3)(C))

6.7

The State assures that there will be reasonable State financial participation in the cost of carrying out the State Plan. (Section 133(b)(3)(D))

6.8

The State assures that services furnished, and the facilities in which they are furnished, under the plan for persons with developmental disabilities will be in accordance with standards prescribed by the Secretary in regulations. (Section 133(b)(5)(A)(i))

6.9

The State assures that buildings used in connection with the delivery of services assisted under the plan will meet standards adopted pursuant to the Architectural Barriers Act of 1968. (Section 133(b)(5)(A)(ii))

6.10

The State assures that services are provided in an individualized manner consistent with the requirements of Section 112 (relating to habilitation plans). (Section 133(b)(5)(B))

6.11

The State assures that the human rights of all persons with developmental disabilities who are receiving treatment, services, or habilitation under programs assisted under this title will be protected consistently with Section 111 (relating to the rights of persons with developmental disabilities). (Section 113(b)(5)(C))

6.12

The State assures that special financial and technical assistance shall be given to agencies or entities providing services for persons with developmental disabilities who are residents of geographical areas designated as urban or rural poverty areas. (Section 133(b)(4)(D))

6.13

The State assures that it has undertaken affirmative steps to assure the participation in programs under this title of individuals generally representative of the population of the State, with particular attention to the participation of members of minority groups. (Section 133(b)(5)(D))

6.14

The State assures that it has made, or will make, an assessment of the adequacy of this skill levels of professionals and papaprofessionals serving persons with developmental disabilities in the State and the adequacy of the State programs and plans supporting training of such professionals and paraprofessionals in maintaining the high quality of services provided to persons with developmental disabilities in the State. (Section 133(b)(6)(A))

6.15

The State assures that there has been provision for the maximum utilization of available community resources, including volunteers. (Section 133(b)(7)(A))

6.16

The State assures that the composition of the State Planning Council meets the requirements of Section 137. (Section 133(b)(1)(A))

SECTION 7:

Attachments

7.1
Appendix: Public Forum — A Summary of Testimony

Introduction:

The Governor's Planning Council on Developmental Disabilities (GPCDD) sponsored a public forum May 4 and 5, hearing testimony from 33 people formally representing 29 regional coordinators, service agencies, providers of advocacy groups. Invitations were mailed to over 40 organizations and a general notice of the forum was printed in the *State Register.* Testimony was solicited on three questions:

1. What is the current status of community services and programs germane to your organization?
2. What are the most critical problems or gaps in programs and services?
3. What recommendations or solutions do you propose to address the problems outlined?

Testimony supports the view that achieving community based services or a decentralized service system will require creative managers and policy makers.

The response to fiscal crisis has often been a kind of "line item blindness" — cutting services that in the long-run are essential for a cost-effective system. (For example: prevention programs like infant stimulation or respite care and family subsidy, alternatives to higher cost residential facilities).

Some witnesses were reluctant to choose a top priority area, stressing the interrelatedness of issues when building a continuum of care at the community level. *If a single theme can be identified it is that the community-based service system is a system under threat — a system fragmented, hampered by contradictory policy and uncertain leadership and eroding because of unstable funding.*

Witnesses spoke of:

- financial disincentives
- a continuum of services incomplete and inaccessible
- slowness of movement through the continuum
- lack of a clear, consistent policy at the top; and

Needs articulated were:

"clear, consistent policies; creative managers, implementing minimum standards and evaluation;" financial incentives to bring mentally retarded persons into the community; incentives to intra-agency coordination and outreach information to build legislative support and supportive community attitudes.

The GPCDD roles were perceived as those of catalyst, advocate and watchdog. In addition to specified responsibilities, the Council was asked, among other things, to support helmet laws, consider the growing problems of head injuries that result in reduced function (estimated at 30,000-50,000 per year nationally), to monitor state school systems and the effects of cuts on services to developmentally disabled persons, and to ascertain the status of special education summer programs for 1982, add vocational

rehabilitation and employment to the list of priority issues, and gear up to support existing statutes and regulations (P.L. 94-142 and 504) that may be weakened.

Some suggestions were made to improve the service system:

1. Coordinate efforts to save money using more family care and generic services with thoughtful evaluation.
2. In response to CSSA, develop a framework for decision-making at the local level.
3. Develop statewide pre-school services.
4. Finance technological systems for severely handicapped to communicate and control their environments.
5. Develop demonstration projects utilizing technology to bring new work opportunities to the handicapped.
6. Give incentives to business to provide contracts and placements.

Five interests of the Council — pre-school, day programs, residential, training and case management — ranked in the following order as they were singled out for comment and/or priority designation.

- Day programs
- Pre-school
- Residential
- Case management
- Training

An overview of comments on each topic follows:

Day Programs (DACs)

- weakest part of service continuum
- most uncertain funding
- in serious jeopardy

1. Major concerns were:
   - likelihood of cuts in existing programs
   - lack of stable funding
   - limited capacity — not uniformly available
   - inadequate staff training, especially for behavior management — readmission problems
   - no resources for upgrading existing DACs
   - inadequate monitoring
2. The continuum of community care no longer exists because of unstable funding of DACs.
3. Day program availability is the key to development of residential services.
4. Should day programs be transferred to the Department of Education and placed on a more stable funding basis similar to school funding?
5. Recent rulings by the Department of Public Welfare suggest that individuals with cerebral palsy may be dropped from day programs (especially those with only physical disability).
6. There was concern about services for individuals with severe behavior problems.

7. The central problem is "how to stabilize the funding base for DACs". (The GPCDD should prepare an analysis of the use of Title 19 funds for review by legislators. What would be the impact of Title 19 funding in programs now being cut?)

   "CSSA (with cuts in support in federal XX and state) is not adequate to meet needs of MR in community".

   "Block grants were a real slap in the face". It is difficult to inform elected officials in so many sites; not enough money to begin with. People fear attempts to save money at county level by moving people back.

   Service levels are unequal with 87 counties deciding 87 different ways how best serve MR persons.

8. One out of four DAC clients is an out-of-county placement, therefore DACs attempt to do financial planning around budget decisions of several counties. Some counties don't want to buy full service.

9. No appropriate or adequate licensing standards for DAC services — ned minimum standards and evaluation.

10. The problem of "reinstitutionalization in the community" is the very real concern with residential providers moving to provide in-house day programming.

11. Less costly transportation plans needed to be developed.

12. Work activity suffers because:

    - there is a continuing lack of available employment and sheltered work.
    - sheltered workshops have had to reduce hours, placements.
    - competitive work is all but impossible in some areas due to high unemployment.
    - DVR has inadequate funds for training.

Preschool

1. Legislation should mandate services for the birth to age four population.

   Because preschool is permissive, not mandatory, birth-3 programs are missing in many areas. One finds grossly inadequate, sporadic provision of services.

2. Preschool services for age birth-3 are an essential part of addressing cultural-familial retardation. Since much familial retardation is environmental and not genetic, prevention programs are highly cost-effective. Children born to high-risk families are inadequately served in the metro area.

   We also need more in-home infant stimulation programs in areas outside the metropolitan region.

3. Preschool programs are the most cost-effective because they may be the key to prevention. Infant stimulation could limit/prevent cultural-familial retardation. Workers see regression of children who are normal at birth. It is possible to lose "10 IQ points a year from age birth-3".

4. Preschool services are not integrated. They are often scattered and overlapping. School districts' policies vary. Todd County has 45 children under age four at home now with no service programs.

   We need a lead agency to coordinate preschool services — like the Department of Education or the Department of Public Welfare.

5. Could education funding be provided to schools for age birth-3 infant stimulation programs?

6. Preschool in some areas is an interagency squabble issue. It is not considered a high-priority need.

7. The interagency policy of education, health, DPW is to "service the most severely handicapped first in infant stimulation".

   What about gains to be made by serving children in high-risk families? Could such a policy prevent mental retardation from occurring in some children?

8. Why are services that are prevention-oriented often the first programs to be cut?

Residential

1. There is a shortage of group homes. (For example: St. Louis County — 100 persons on ICF-MR waiting lists.)

2. We need Class B facilities for people still in state hospitals and for multiply handicapped.

3. We need SILS and adult foster care. The SILS concept is not "taking off" in counties.

4. We need more respite care to encourage cost effective in-home care and Title 19 to fund it.

5. There is a slowness of movement through the residential continuum.

6. Work with DPW on consistent rate-setting to provide incentives for movement. Arbitrary, contradictory actions at DPW impede progress. (Example: approved $73 rate Class A — $95-100 for Class B severely autistic, $48 per diem for an existing facility that changed from Class A to Class B.)

7. There are residential needs for special groups:

   - CP-physically impaired
   - autism-with attention to behavior management needs
   - behavior problem clients

8. Housing and transportation were the most important independent living needs of those job-ready, handicapped individuals who contacted centers for independent living.

9. Cuts in SSI are affecting people's potential to achieve greater independence.

10. Metro needs include:
    a. foster care for both children and adults.
    b. some specialized group living facilities for individuals with behavioral problems.
    c. SILS to stimulate client movement through the system.

11. Respite care legislation should create a licensed provider status for respite programs.
12. We need increased family subsidies to provide incentives for families to keep family members at home.

Case Management

1. A need in Southwestern Minnesota is for appropriate supportive services like O.T., P.T., dentists and eye doctors.

   Each region should have a central agency responsible for public education, public awareness and referrals.
2. We have a fragmented, decentralized, pre-cooperative system. Mandate cooperation at the regional level. All coordinated activity is voluntary.
3. There is a lack of accessible information on available services for DD — among both human service professionals and consumers.
4. There is duplication of services at the intake level. Standardize procedures or accept others' evaluation.
5. Case management could be greatly simplified. We need a training network.
6. Case management is the key to other things happening.
7. Every agency is doing case management but nobody is doing the total job of case management.

Training

1. There should be coordination of training offered to groups at the local level to insure access to training programs. It is impractical for providers to do training alone. It wastes resources.
2. School special education staffs could be a resource for trainees. Should training be coordinated by local schools?
3. There is a need for training at the community facility level for behavior management and also for dealing with multiply-handicapped clients.
4. There should be training for persons offering generic services — teachers, physicians and nurses (especially for epilepsy management).
5. Groups with behavior management needs are people with autism and epilepsy. More people with seizures will be in community facilities.
6. Epilepsy management requires knowledge of medical treatment, first aid and psycho-social symptoms. Resources include the Minnesota Epilepsy League (training manual and AV tape) and the Governor's Advisory Task Force on Epilepsy.

   — Cite effective training programs — disseminate them.
7. Examine licensing mechanics to insure that the licensing process requires training programs.

Other issues eliciting frequent comments were: policy development, DPW leadership, monitoring and evaluation of community services, prevention, family supports and public education about developmental disabilities. Funding concerns were expressed by most people giving testimony. Remarks not included in the five central topic areas are summarized below:

Funding: Many items on the list were mentioned repeatedly.

1. A major problem is policy makers' lack of a coherent view of the service system. Decisions to reduce funding are made without consideration of their effects on the rest of the system. The state has not planned for funding the service continuum -- leading to "line item blindness" and protection of single funding pockets.
2. With movement to block grants there is sympathy for county funding problems and recognition that funding changes should be consistent with deinstitutionalization policies. Needs are financial incentives to move people to least restrictive environments. At present there are "substantial financial disincentives to place MR persons in the community."
3. Lack of a stable funding base for DACs, sheltered workshops and other employment services has eroded commitment to a "continuum of care" in the community. Counties are reluctant to encourage Title 19 for DACs because of "fear they will pick up an evergrowing tab".
4. Home counties of "out-of-county placements" don't want to pay for full service in DACs leading to requests for reduced service.
5. More funding is needed for rehabilitation and employment training. Facilities are functioning at or near capacity.
6. Dollars and incentives are needed for counties to serve the more severely disabled.
7. Financial incentives should be offered to businesses to work with sheltered workshops and to employ developmentally disabled people.
8. Continue use of Title XIX.
9. Rethink social security eligibility determination.

Summary:

Assessments of the current status of community services suggest a system where gains are being eroded by funding instability and uncertain commitments to deinstitutionalization. Gaps in services were identified in all regions with day programs and preschool needs mentioned most often. If the Governor's Planning Council on Developmental Disabilities is to take the proactive stance called for by most organizations, it will need strategies to deal with a "problem" agenda including: (1) broadening the base of support for policies of community care and treatment, (2) gaining financial stability and financial incentives consistent with policy, (3) selling the cost effectiveness of community care and less restrictive programming, (4) working in prevention, and as one person suggested, (5) considering whether there are other, as yet untried, forms for delivering essential services at the community level. The context for planning is one in which fiscal restraints could continue to exist and redesign of service systems may be a productive alternative to piece-meal cuts in existing services.

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